Delaware Health and Social Services

Division of Public Health

Attachment A

Application for Becoming a Recognized State School Health Services Provider for Non-Contracted Entities

Cover Sheet

Name of Applicant Organization and Tax ID#:	
Applicant Organization Contact: Name: **Phone:** **Email:**	
School Name(s) and locations (addresses) of the Center(s):	
Source of Health Services Program Funding: (check all that apply)	Source — Amount, if known _____None _____Local/ County Funds _____ _____ Other health providers _____ _____ Other State Funds _____ _____ Private donors/ Organizations _____ _____ Federal Funds _____ _____ Other _____ _____ In-Kind _____
Program Description: (Please provide a description of the program and services to be provided.)	

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Cover Sheet cont.

Services to be provided:	_____ Diagnosis and treatment of acute medical conditions _____ Identification and referral of chronic conditions _____ Mental health counseling and referral. _____ Prescribing and/or dispensing of non-Prescription/prescription medications. _____ Health education _____ Immunizations _____ Nutrition counseling, consultation and/or education _____ Minor laboratory tests _____ Diagnosis and treatment of STDs (subject to School Board or governing entity approval) _____ HIV Testing and Counseling Services (subject to School Board or governing entity approval) _____ Reproductive Health Services (subject to School Board or governing entity approval) _____ Other
ASSURANCES:	
Compliance with DE SBHC Regulations. I have read and agree to comply with the State of Delaware Regulation(s), 18 Del.C. §§3365 & 3571G	_____ Signature _____ Title

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Cover Sheet cont.

	_____ Date
Updating of contact Information: I agree to notify DPH if any of the information provided in this application to become a State Recognized School Health Services Provider changes. _____ **Date of Provider Application:** Application for becoming a State Recognized School Health Services Provider is submitted on _____.	_____ Signature _____ Date _____ _____ Signature _____ Date

Please complete Attachment A and B, then submit completed package to:

Division of Public Health
School-Based Health Centers
1351 W. North Street Suite 103
Dover, DE 19904

For Questions call (302) 608-5741